NOTICE OF INDEPENDENT REVIEW DECISION

Date: October 1, 2003

RE: MDR Tracking #: M2-03-1734-01
IRO Certificate #: 5242

____ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to ____ for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

____ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a Neurosurgeon physician reviewer who is board certified in Neurosurgery and has ADL certification. The Neurosurgeon physician reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History
This claimant is reported from the records to have an injury of a poorly described nature to his back on ___. The following evaluation: he had MRI of his neck, back and lower back because of pain in these areas. The MRI was performed on 01/19/01 and showed mild "disc disease" at T10-11; otherwise no abnormalities. He was treated conservatively and the records reflect no change in his status of back pain since mid 2001. He is currently being followed by a Neurosurgeon, ____ who has requested a repeat MRI of the thoracic spine because of point tenderness at T5-6 in the midline.

The specific question involved in this referral is whether or not a repeat thoracic MRI scan is medically necessary based upon the patient's injury and treatment history.

Requested Service(s)
Thoracic MRI scan.

Decision
My opinion is that I agree with the insurance company that this requested MRI is not medically necessary.

Rationale/Basis for Decision
The first MRI scan revealed no pathology at T5-6. The patient's clinical condition has not changed in at least one year, making the likelihood of finding new pathology now quite remote.

If disputing a spinal surgery prospective decision, a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **10** (ten) calendar days of your receipt of this decision (28 Tex. Admin. Code 142.5(c)).

If disputing other prospective medical necessity (preauthorization) decisions, a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) calendar days of your receipt of this decision (28 Tex. Admin. Code 142.5(c)).

This decision is deemed received by you 5 (five) days after it was mailed or the date of fax (28 Tex. Admin. Code 102.5(d)). A request for a hearing and a **copy of this decision** must be sent to:

Chief Clerk of Proceedings / Appeals Clerk
P.O. Box 17787
Austin, Texas 78744
Fax: 512-804-4011

The party appealing this decision shall deliver a copy of its written request for a hearing to other party involved in this dispute.